***Patient Name:** _____ ***Date of Birth:** _____ Telephone #: _____

***Purpose of Disclosure**: ☐ Insurance ☒ Provider ☐ Attorney ☐ Personal ☒ Other: ___Orcas transfer_____

INFORMATION TO BE RELEASED FROM:	*** INFORMATION TO BE RELEASED TO:**
UW - Orcas Clinic	**Island Hospital / Orcas Clinic** *(Organization/Person)*
1550 North 115th St., MS-358828 *(Address)*	***1211 24th Street)*** *(Address)*
Seattle, WA 98133 *(City, State, Zip)*	***Anacortes, WA 98221*** *(City, State, Zip)*
(206)668-1616/(206)668-1920 *(Phone/Fax)*	***(360)299-1326/(360)299-1347*** *(Phone/Fax)*
	Department/Clinic: **Medical Records**

*** Type of information** *(check appropriate box):*

- ☐ **Pertinent Hospital Medical Records from date:** _____ **to date:** _____
- ☐ **Pertinent Clinic Medical Records from date:** _____ **to date:** _____
  (a fee may be charged for this service)
- ☐ **All Medical Records** *(a fee may be charged for this service)*
- ☐ **Images** *(specify type)* _____
- ☒ **Other** *(specify – discharge summary, operative reports, lab reports, billings, etc)* ***CCD – Continuity of Care Document or last 12 months clinic records (all)***

****Patient Authorization*:**
I understand that my records may contain information regarding the diagnosis or treatment of the following conditions and give my consent to include them in this records request *(patient initials required):* ____ HIV/AIDS ____ sexually transmitted diseases ____ drug and/or alcohol abuse ____mental illness ____psychiatric condition

This authorization is valid until** _____ ***(date) OR **when the following event occurs:** _____
(State when Island Hospital is no longer authorized to disclose your information based on this authorization. If no date or event is listed, the authorization will be effective for 30 days from the date signed by you)
Note: Authorization to disclose your information *to an employer or financial institution* can only be effective for a maximum of one year from the date signed by you. (Reference RCW 70.02)

Minors **(defined by law as a person under the age of 18 years unless otherwise noted for specific conditions):** A minor patient's signature is required in order to release the following information:

1. Conditions relating to birth control, abortion or prenatal services (at any age per Washington State Law)
2. Sexually transmitted diseases (if age 14 or older)
3. Alcohol and/or drug abuse and mental health conditions (if age 13 and older)

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to Island Hospital Privacy Officer, 1211 24th Street, Anacortes, WA. 98221.

I understand I have the following rights to:

- Inspect or receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I understand that once Island Hospital discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy Laws.

I understand that the confidentiality of these records will be protected by Island Hospital and its clinics under the authority of Federal (HIPAA, 45 CFR parts 160 and 164) and/or State of Washington laws. I also understand that some of my records may be protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in these regulations.

By signing this page, I acknowledge that I have read and agree to the terms on this page.

***Signature** _____ ***Date** _____
(Patient or Person Authorized to give Authorization)
***If signed by person other than patient, provide reason, relationship to patient, or description of authority**: _____

ID Confirmed_____ ***Date Records Copied*** _____ ***Copied By*** _____ ***Department/Clinic*** _____